

Amended MDR Tracking Number: M5-04-3460-01 (**Previously M5-04-1023-01**)

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-08-03.

This AMENDED FINDINGS AND DECISION supersedes all previous Decisions rendered in this Medical Payment Dispute involving the above requestor and respondent. The Medical Review Division's Decision of 05-11-04 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 06-14-04. An Order was rendered in favor of the Requestor. The Respondent appealed the Order to An Administrative Hearing.

The IRO reviewed electrical stimulation, unlisted modality-acupuncture, office visit with evaluation unlisted therapeutic procedure and office visits rendered from 12-10-02 through 05-06-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-25-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12-10-02	99213	\$48.00 (1 unit)	\$0.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information for DOS 12-10-02. Reimbursement recommended in the amount of \$48.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12-16-02 and 3-25-03	99215	\$206.00 (1 unit @ \$103.00 X 2 DOS)	\$0.00	NO EOB and D  DOS 12-16-02 denied D code  DOS 3-25-03 denied NO EOB	\$103.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for DOS 12-16-02 and 03-25-03. Carrier audited DOS 12-16-02 as DOS 12-10-02 and incorrectly denied as a duplicate. Reimbursement recommended in the amount of \$103.00 X 2 DOS = \$206.00
1-14-03 through 4-8-03 (5 DOS)	99213	\$240.00 (1 unit @ \$48.00 X 5 DOS)	\$0.00	NO EOB	\$48.00	Rule 133.304(c)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$48.00 X 5 DOS = \$240.00
4-29-03	97139-AC	\$96.00 (2 units)	\$0.00	N	DOP	96 MFG MEDICINE GR (I)(9)(b)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
TOTAL		\$590.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$494.00

## ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Amended Decision is applicable for dates of service 12-10-02 through 04-08-03 in this dispute.

This Amended Findings and Decision and Order is hereby issued this 16<sup>th</sup> day of July 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

February 23, 2004

## **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-1023-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurology. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### **Clinical History**

This case concerns a 35 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he fell from a scaffold approximately 12 feet in the air. The patient was evaluated in the emergency room where he underwent a CT scan that was reported as normal and was released the same day. The patient began a physical therapy rehabilitation program for treatment of neck pain, headache, vertigo, and low back pain.

The patient underwent a head MRI on 10/16/01 that was reported as normal and an EEG. From 5/1/02 through 5/22/02 the patient underwent neuropsychiatric testing that indicated conversion disorder with mixed presentation, recurrent moderate major depressive disorder, rule out cognitive disorder, and borderline intellectual functioning. The diagnoses for this patient have included closed head injury, post concussion syndrome, conversion disorder, lumbar and cervical strain. The patient was also diagnosed with global aphasia for approximately six months after the injury. Treatment for this patient's condition has included physical therapy, medications, and psychotherapy. The patient has also undergone Electro-Auricular Acupuncture for treatment of symptoms related to his closed head injury.

### **Requested Services**

Electrical Stimulation, unlisted modality-acupuncture, office visit evaluation (40 min), office visits evaluation (15 min) from 12/10/02 through 5/6/03.

### **Decision**

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

### **Rationale/Basis for Decision**

The \_\_\_\_ physician reviewer noted that this patient concerns a 35 year-old male who sustained a work related injury to his neck, head, and low back. The \_\_\_\_ physician reviewer indicated that the patient was diagnosed with a mild closed head injury, and neck and back strains. The \_\_\_\_ physician reviewer noted that the patient complained of symptoms that included vertigo, aphasia and pain. The \_\_\_\_ physician reviewer also noted that the patient underwent a MRI of the brain and neck, and an EEG. The \_\_\_\_ physician reviewer explained that the neurological testing results were consistent with conversion disorder. However, the \_\_\_\_ physician reviewer further explained that as of late 2002, neurological and physiatry evaluations revealed no significant diagnoses for this patient. Therefore, the \_\_\_\_ physician consultant concluded that the electrical stimulation, unlisted modality-acupuncture, office visit evaluation (40 min), office visits evaluation (15 min) from 12/10/02 through 5/6/03 were not medically necessary.

Sincerely,